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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **A6567**

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b. 30 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Co Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 1615-3	
f. STREET ADDRESS 7302 -welle Blvd		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Frank Harris Allen		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4. SEX M	5. COLOR OR RACE W	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH May 5, 1895
8. AGE (In years at birthday yrs.) 64	9. IF UNDER 1YEAR Months 0 Days 0	10. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Falermann Real estate		10b. KIND OF BUSINESS OR INDUSTRY Real estate	
10c. BIRTHPLACE (State or foreign country) Pa		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Harris Allen		14. MOTHER'S MAIDEN NAME Julie Creas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War I		16. SOCIAL SECURITY NO. 123-45-6789	
17. INFORMANT Edward L Allen, Prince Frederick		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO (b) _____ DUE TO (c) _____	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Was eating dinner alone. He called a friend and decided to go in a car.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) End of scuff get in a car	
20c. TIME OF INJURY Month, Day, Year Hour 6 p.m. 6/1/39		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Bethel Calvert		(County) Calvert (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE H.W. Ward		DATE SIGNED 6/1/39	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/39	
22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE JUN 3 '59		24b. REGISTRAR'S SIGNATURE Robert L. Keene	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabell</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Puine Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabell County Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Holland Point</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>F</i>	Middle <i>RUFUS</i>	Last <i>HERMAN</i>
4. DATE OF DEATH	Month <i>June</i>	Day <i>3</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 6, 1873</i>
9. AGE (in years last birthday) <i>86 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Fishing</i>	11. BIRTHPLACE (State or foreign country) <i>Cabell Co., Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>H.S.G.</i>
13. FATHER'S NAME <i>Benjamin H. Bowen</i>	14. MOTHER'S MAIDEN NAME <i>Susan Smith</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT <i>Edward Bowen - Barbours Ind.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2-10</i> , 19 <i>59</i> , to <i>3 May</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2-10</i> , 19 <i>59</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>G. J. WEEMS</i> M.D.			
22a. BURIAL, CREMATION; REMOVAL (Specify) <i>Burial June 5, 1959</i>	22b. DATE THEREOF <i>June 5, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Ashley Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Barbour - Cabell Co - Ind.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness & Son - Mutual, Inc.</i>		24a. ADDRESS <i>ADDRESS</i>	24b. REC'D BY REGISTRAR DATE <i>JUN 8 '59</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. You may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6577 Item 9 FilmG244 6-22-59 et

06569

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Spencer</i>	Middle <i></i>	Last <i>Freeland</i>	
4. DATE OF DEATH	Month <i>June</i>	Day <i>10</i>	Year <i>1959</i>	
S. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-9-1890</i>	
9. AGE (In years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. CITIZEN OF WHAT COUNTRY <i>A.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>A.S.A.</i>	
13. FATHER'S NAME <i>James Freeland</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Morse</i>	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Emma Freeland</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Armenia - cerebral hemorrhage</i> (b) DUE TO (c) DUE TO <i>Hypertension c.v.d.</i>	INTERVAL BETWEEN ONSET AND DEATH <i>10 days.</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/3</i> , 19 <i>59</i> , to <i>6/11</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6/8</i> , 19 <i>59</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>St. Thomas</i> DATE SIGNED <i>6/10/59</i>			
ACTUAL SIGNATURE <i>R. W. Villareal</i>	PHYSICIAN'S NAME (Type) <i>Roberto de Villareal, M.D.</i>			
22a. BURIAL/CREMATION REMOVAL (Specify) <i>June 13, 59</i>	22b. DATE THEREOF <i>June 13, 59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Youngs</i>	22d. LOCATION (City, town, or county) (State) <i>Huntingtown, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sevell, Prince Fred,</i>	ADDRESS <i>Youngs</i>	24a. REC'D BY REGISTRAR DATE JUN 17 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	

BT-31007149-H124H TO TELA MA 32 STATE OWNERSHIP

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06570

6578

Item 9 film G244 6-30-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Calvert		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	W. Beach		c. STATE
c. LENGTH OF STAY IN 1b			b. COUNTY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
			d. STREET ADDRESS
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH
Bernard	Joseph	Garrett		Month Day Year

5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
Male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 21, 1894	1618	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Operating	Selling fruit	W. Beach	W. Beach Md

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Bernard J. Garrett	Lucy Pearson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	243-16-6990	Mrs. B. J. Garrett	W. Beach Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 782.4	1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)	
DUE TO	
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Was taken with pain in chest & abdomen	

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
1:30 p.m.	6/20 1959	Home	W. Beach Calvert Md	

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .

ACTUAL SIGNATURE	H. W. Ward	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type)	H. W. WARD	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	6/20/59
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	June 23, 1959	Mt. Harmony	W. Beach Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 24 '59	24b. REGISTRAR'S SIGNATURE
Hutchins Funeral Home	Dwight Rd.		Collins S. Kress

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06571

6579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1 X M 064 I 0 2 2 3 VS. A15ME(5) 5M 9/55	1. PLACE OF DEATH a. COUNTY Cabell MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WV b. COUNTY QC				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater 02x2				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Co Hospital	d. STREET ADDRESS 750 Mayo Rd	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Richard	First	Middle Haase	4. DATE OF DEATH Month 6 Day 17 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/89	9. AGE (In years at time of death yrs.) 79	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kerner	10b. KIND OF BUSINESS OR INDUSTRY Hair Stylists	11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Justin Haase	14. MOTHER'S MAIDEN NAME Miss Alberta					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 051-14-0149	17. INFORMANT Hospital Chas Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 782.4 DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Very seen by a local MD					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE H.W. Ward	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 6/17/59		
EXAMINER'S NAME (Type) H.W. Ward	22b. DATE THEREOF June 22, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Crematory	22d. LOCATION (City, town, or county) Prince George County, Maryland	(State)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24a. REC'D BY REGISTRAR DATE JUN 22 '59	24b. REGISTRAR'S SIGNATURE China S. Trauma				
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home	ADDRESS Annapolis Md.					

81. BROWNSVILLE - MASH TO THE EAST OF YANKEE CITY - 0800-0830
MASH TO STATION CREEK - 0830-0855
VALLEY EXAMINER - 0855-0900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06572

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brunkirk</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brunkirk</i>	d. STREET ADDRESS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Larry</i>	Middle <i>James</i>	Last <i>Jenkins</i>
4. DATE OF DEATH	Month <i>6</i>	Day <i>28</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 27 1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>Mersey Savoy</i>
13. FATHER'S NAME <i>Dennis Jenkins</i>	14. MOTHER'S MAIDEN NAME <i>Mersey Savoy</i>	Address <i>Dennis Jenkins, Brunkirk Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Strangulation when he got hung in his crib</i>
DUE TO <i>9240</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>hung in his crib</i>			
DUE TO <i>(b)</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>hang & get rid head of clapt</i>	
20c. TIME OF INJURY <i>Hour p. m. 6 28</i>	Month, Day, Year <i>1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or Town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i>	DATE SIGNED <i>6/26/59</i>		
EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>moses</i>	22b. DATE THEREOF <i>6-27</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>moses</i>	22d. LOCATION (City, town, or county) (State) <i>A.A. County Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell Jr. Frederick</i>	ADDRESS <i>2063203XLS</i>	24a. REC'D. BY REGISTRAR <i>JUL 1 1959</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Ward</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE SOUTHERN STATE DEPARTMENT OF HEALTH-EDUCATION &
MEDICAL EXAMINER'S OFFICE

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1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

116573

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution, residence before admission]	
<i>Cabot</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Lusby		<i>Lusby</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		<i>403 Talbot St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Louis</i>		<i>Cecil</i>	<i>Luber</i>
4. DATE OF DEATH		Month	Day
		8	13
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH
<i>M</i>			<i>5/29/02</i>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Gas Pkg.</i>		<i>W. Granville Laurel Md</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>W. Granville Laurel Md</i>		<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Louis Luber</i>		<i>Cecilia Pauline Siege</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>720-0-5474</i>	
17. INFORMANT		Address <i>403 Talbot St</i>	
<i>Mrs Louis C. Luber Laurel Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cardiac failure</i>	
<i>782.4</i>		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>(b)</i>	<i>Rowing lost in storm</i>
DUE TO		<i>(c)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>4:00</i> p. m.		Month, Day, Year <i>6/13 1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) <i>Lusby</i>	
		(County) <i>Calvert</i>	
		(State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		DATE SIGNED <i>6/13/59</i>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/16/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Snug Hill Cemetery Laurel Md</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Danielson Laurel Md</i>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE JUN 18 '59	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Trahan</i>	

116574

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Washington DC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Beach</i>		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
f. STREET ADDRESS <i>3942 Ames St N E</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frank Alwyn Mann</i>		First <i>Frank</i>	Middle <i>Alwyn</i>
Last <i>Mann</i>		4. DATE OF DEATH Month <i>6</i>	Day <i>20</i> Year <i>1959</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <i>June 22/892</i>
9. AGE (in years last birthday) <i>60 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Food prep Capellano</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Food</i>	11. BIRTHPLACE (State or foreign country) <i>Wash DC</i>
12. CITIZEN OF WHAT COUNTRY? <i>V.G.A.</i>			
13. FATHER'S NAME <i>Jesse Mann</i>		14. MOTHER'S MAIDEN NAME <i>Johanna Carol</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or otherwise) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Francis A. May Jr</i>
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>782.4</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Was found dead sitting in a chair on June 20th he had been lying</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>4:30</i> p.m. <i>6/20</i> 19 <i>59</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, 120 ^f , (City or town) factory, street, office bldg., etc.) <i>Home W. Beach Calvert MD</i>
		(County) <i>Calvert</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <i>6/29/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/1/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>
22d. LOCATION (City, town, or county) <i>Washington DC</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Timothy Haulan</i>		ADDRESS <i>3831 Ga Ave NW</i>	24a. REC'D BY REGISTRAR DATE JUN 23 '59
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	

DEPARTMENT OF STATE - BUREAU OF POLITICAL-MILITARY AFFAIRS
ATTACHÉ COUNSELOR FOR POLITICAL AFFAIRS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116575

6583

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Cabell</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonards</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Leonards</i>	
e. STREET ADDRESS <i>Bethesda MD 15202</i>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. NAME OF DECEASED (Type or print) <i>Donald Ward</i>		8. DATE OF DEATH Month Day Year <i>March 14 1959</i>	
9. SEX <i>M</i>	10. COLOR OR RACE <i>W</i>	11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12. AGE (In years last birthday) 10 yrs. IF UNDER 1 YEAR Months Days Hours Min. <i>Nov. 4 1948</i>
13. FATHER'S NAME <i>Donald J. Ward</i>		14. MOTHER'S MAIDEN NAME <i>Katharia Moran</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Address</i>	
17. INFORMANT <i>Donald Ward Bethesda MD</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>929.8 Brown</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>brown</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Found floating face down</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>3 p.m. 6/14 1959</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fall down in swimming 30 min</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>3 p.m. 6/14 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At Ches. Bay</i>	
20f. (City or town) <i>Cabell MD</i>		(County) <i>Arlington</i>	
		(State) <i>Virginia</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		DATE SIGNED <i>6/14/59</i>	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-18-59</i>	
22c. NAME OF CEMETERY OR CREMATORIALy <i>Arlington Nat'l Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR DATE JUN 17 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06576

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Leonard</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
d. STREET ADDRESS <i>322 Cedar Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Clark Richard Neal</i>		First <i>R</i>	Middle <i>B</i>
4. DATE OF DEATH Month <i>6</i>		Day <i>14</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 10, 1951</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>-</i>		12. CITIZEN OF WHAT COUNTRY? <i>-</i>	
13. FATHER'S NAME <i>Lawrence Richard Neal</i>		14. MOTHER'S MADDEN NAME <i>Phyllis Jane Clark</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>H. W. Ward</i>		Address <i>100 N. Calvert St., Baltimore, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>929.8</i> DUE TO <i>Grown</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Found floating face down in Chesapeake Bay</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Was swimming</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>3 p.m. 6/14 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Chesapeake Bay</i>
20f. (City or town) <i>Long Beach</i>		(County) <i>Calvert</i>	
(State) <i>Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		DATE SIGNED <i>6/14/59</i>	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-17-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>		22d. LOCATION (City, town, or county) <i>Rockville, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>JUN 16 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>	

61 BROWNSVILLE-DOVER HARBOR STATE OWNED
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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6585 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06577

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
<i>Calvert</i> <i>Maryland</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Bessey Federal</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Calvert Co.</i>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Bessie</i>		<i>Plater</i>	
4. SEX		5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>M</i>		<i>C</i>	<i>Nov. 16,</i>
7. DATE OF BIRTH		8. AGE (In years last birthday)	9. IF UNDER 1 YEAR Months Days Hours Min.
		<i>17 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Student-Farm laborer</i>			<i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY?		<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Wardell Plater</i>		<i>Bessie Reid</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
<i>✓ 825 X</i>		<i>220 36 7400</i>	<i>Bessie Reid Huntington Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Broken neck and fractured skull</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
<i>✓ 825 X</i>		<i>Auto accident Charles Co. Md</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6 27 59 p.m. 12 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Huntington</i> <i>Huntington</i> <i>W.M.D.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		<i>H.W. Ward</i>	
ACTUAL SIGNATURE		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>6-30-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL	
		<i>Bluem Point</i>	
22d. LOCATION (City, town, or county) (State)		<i>Calvert Co. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>P.T. Sawell, Bessey Fedral</i>		24a. REC'D BY REGISTRAR JUL 2 '59 DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Moore</i>	

19 M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06578

Reg. Dist. No.

6586

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE WHERE Deceased lived. If Institution: Residence before admission a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Owings Md</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Robert Smith</i>		4. DATE OF DEATH Month Day Year <i>6 22 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 25 1906</i>
9. AGE (In years last birthday) yrs. <i>52</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mercantile store</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Md</i>	12. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>
13. FATHER'S NAME <i>Robert S Ward Jr</i>	14. MOTHER'S MAIDEN NAME <i>Ella Hopkins</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>217-32-8444</i>		17. INFORMANT <i>John W. Ward Daring Md</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Candidias, if any, which gave rise to immediate cause</i> (a), stating the underlying cause last. <i>782.4</i> DUE TO <i>Candidias of failure</i>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>9 p.m. 6/22 1959</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Found dead in bathroom</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>9 p.m. 6/22 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. CITY OR TOWN (County) <i>Owings Calvert Md</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED <i>6/22/59</i>	
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 25, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Smithville</i>
22d. LOCATION (City, town or county) <i>Dunkirk Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home, Owings Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 26 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6587

CERTIFICATE OF DEATH

06579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Princes Frederick</i>		c. LENGTH OF STAY IN 1b <i>11 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Thomas Wayne Wood</i>		First <i>Thomas</i>	Middle <i>Wayne</i>
4. DATE OF DEATH <i>8/19/59</i>		Last <i>Wood</i>	Month Day Year Month Days Hours Min. <i>8 19 1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>01/13/1923</i>
9. AGE (In years last birthday) <i>66 yrs.</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Highway Department</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>		11. BIRTHPLACE (State or foreign country) <i>America</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Thomas S. Wood</i>	
14. MOTHER'S MAIDEN NAME <i>Rachael Fisher</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>219-36-8244</i>		17. INFORMANT <i>Hospital Client Prince Frederick Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>782.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/19/59</i> to <i>6/19/59</i> , 1959, that I last saw the deceased alive on <i>6/19/59</i> , 1959, and that death occurred on <i>6/19/59</i> PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. W. Ward</i>		ADDRESS (Street, city or town, state) <i>Owings Mill</i> DATE SIGNED <i>6/19/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 21, 1959</i>		22b. DATE THEREOF <i>June 21, 1959</i>	
22c. NAME OF CEMETERY OR CEMETORY <i>Friendship</i>		22d. LOCATION (City, town, or county) <i>Friendship Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home, Owings Mill</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 24 1959</i>	
ADDRESS <i>Arthur S. Davis</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

